

# Athlete Application for Participation

(Valid for 3 Years from the Date of the Physical Exam)



Special Olympics

Massachusetts

Area and Local Program Shrewsbury

Please print clearly. All information is required.

Name \_\_\_\_\_

Social Security Number (optional) \_\_\_\_\_ Male ☐ Female ☐ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Phone # \_\_\_\_\_-\_\_\_\_-\_\_\_\_

Street Address or PO Box \_\_\_\_\_ Apt # \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ ZIP Code + 4 \_\_\_\_\_-\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Emergency Contact Phone # \_\_\_\_\_-\_\_\_\_-\_\_\_\_

## HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies:		Easy bleeding	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environmental: _____		Emotional/psychiatric/behavioral	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food: _____		Heart disease/heart defect*	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insect stings/bites: _____		Hepatitis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicines: _____		High blood pressure*	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma*		Immunizations up-to-date	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blind*		Date of last tetanus immunization ____/____/____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visually impaired		Needs medication (see "Medications" table below)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bone or joint problem		Requires extra supervision	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concussion or serious head injury*		Seizures/epilepsy/fainting spells*	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deaf		Shunts	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing impaired		Special diet	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes*		Tobacco use	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Down Syndrome (see below)		Other: _____	

(\*) Requires physical examination if new problem

Medications (if applicable): Please print medication name, amount, date prescribed and number of times per day medication is given.

Medication Name	Dosage	Date Presc.	Times per day	Medication Name	Dosage	Date Presc.	Times per day

Special Olympics Massachusetts (SOMA) specifically has my permission (both during participation and anytime thereafter) to use my/my child's/my ward's likeness, name, voice, and words in television, radio, film, newspaper, magazines, and any other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics Massachusetts.

I understand that if a medical emergency should arise during my/my child's/my ward's participation in any SOMA activity and I am not able to give my consent for treatment, that SOMA is authorized to take whatever measures are necessary to protect my health and well-being including hospitalization.

Signature of parent/legal guardian/adult athlete (over 18) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## SECTIONS BELOW TO BE COMPLETED BY EXAMINING PHYSICIAN:

**For Athletes With Down Syndrome:** Persons with Down syndrome should have a lateral x-ray of the cervical spine in hyper flexion and hyperextension. The interpretation of the radiographs should include measurements of the atlanto-dens interval.

**Yes** ☐ **No** ☐ Has an x-ray evaluation for atlantoaxial instability been done? Date of x-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ ☐ If yes, was it positive for atlantoaxial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

I have reviewed the above health information and have performed the above examination on this athlete within the past 6 months and certify that the athlete can participate in Special Olympics. **RESTRICTIONS:** \_\_\_\_\_

Signature of Examiner \_\_\_\_\_ Exam Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(no office stamps accepted without provider's signature)

Examiner's Name \_\_\_\_\_

Street Address or P.O. \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone # \_\_\_\_\_-\_\_\_\_-\_\_\_\_

LAST NAME, FIRST NAME:

FORM EXPIRATION DATE

